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Co-Chairs, Ways & Means
Subcommittee on Human Services

OREGON LEGISLATURE

MEMORANDUM

To: Interested Stakeholders
From: Senator Alan Bates and Representative Tina Kotek
Re: System Reform for Mental Health and Addiction Services
Date: March 19, 2009

Recognizing the need to maximize the quality, effectiveness, and efficiency of Oregon's mental health care and addictions treatment system, we would like to begin a dialogue about options for system reform. Since the ultimate goal is improving the overall health of Oregon's population, it is integral that we consider ways to integrate physical and mental health care and to incorporate that care with wraparound services. Reducing administrative and delivery costs is also critical in this difficult budget environment in order to maintain current service levels of available care.

To achieve a more integrated, efficient overall health system, we propose two changes for discussion:

1. *A change in management* – Contracting with the state's Medicaid Managed Care Organizations (MCO's) to manage funds to purchase core mental health, addiction, and physical health services.

Consolidating the management of federal, state, and Medicaid-funded Addictions and Mental Health (AMH) and Department of Medical Assistance (DMAP) programs through contracts with MCO's on a regional basis would achieve two primary goals:

- (a) Integrating and managing services and funding for mental and physical health care.
- (b) Creating a simpler, more efficient and cost-effective delivery system.

Crisis, civil commitment, and other non-core services may continue to be managed by the counties. Counties would also be free to develop custom services and programs that are important to their communities.

2. *A change in payment structure* – Developing a system of payment that rewards positive outcomes for patients, not the number of patient-provider encounters.

A payment system based on outcomes (as opposed to the current fee-for-service model) emphasizes provider accountability and creates a financial incentive to manage patient services in a way that is efficient and results in better outcomes. An outcome-based compensation model would be based on some kind of case rate or capitation rate.

Our goal is to have these two proposed changes serve as the starting point for an important conversation. We fully expect these kinds of changes to be considered for 2009-11 as a voluntary demonstration project. Only those counties or regional county groups who are motivated to make these changes would pilot and demonstrate the elements of this concept. We will begin the discussion at our subcommittee meeting on Wednesday, March 25th. We fully anticipate a series of stakeholder meetings to follow that opening dialogue. Thank you in advance for your willingness to engage in this discussion.